



MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236



**REPORT OF
SETTLEMENT, JUDGMENT OR ARBITRATION AWARD
Required by Section 801, 801.1, 802, 803.2 Calif. Business and Professions Code**

PLEASE CHECK THE APPROPRIATE BOX:

- | | |
|--|---|
| <input type="checkbox"/> Section 801 (Insurance Company) | <input type="checkbox"/> Section 802 (Self-insured) |
| <input type="checkbox"/> Section 801.1 (State or Local Government) | <input type="checkbox"/> Section 803.2 (Employer-Prof. Corp., group practice, health care facility or clinic) |

INSURER/PUBLIC ENTITY:

- | | |
|------------|--------------|
| 1. Name | 2. Telephone |
| 3. Address | |

PHYSICIAN/PROVIDER:

- | | |
|---|---|
| 4. Name | 5. License Number
Specialty/subspecialty |
| 6. Address(es) | 7. Policy Number |
| 8. Counsel's Name | 9. Counsel's Phone Number |
| 10. Address | |
| 11. NOTE: On reverse, enter full name(s) of other physicians or health care providers who were claimed or alleged to have acted improperly, Whether or not such persons were named as defendants, or whether or not any recovery or judgment was against such persons. If any monies were paid on behalf of those listed, please indicate the amount. | |

PLAINTIFF/CLAIMANT:

- | | |
|--|---|
| 12. Name | 16. Date of Admittance |
| 13. Address(es)
Business
Residence | 18. Hospital Chart Number |
| 14. Hospital Name and Address | 20. Deceased <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Incident Date | 22. Counsel's Phone Number |
| 17. Patient Name | |
| 19. Patient Date of Birth | |
| 21. Counsel's Name | |
| 23. Address | |

24. Enter on reverse, a description or summary of the facts upon which each claim, charge or judgment rested including date of occurrence. Explain specifically whether death or personal injury occurred as a result of the negligence, error or omission in practice, or rendering of Unauthorized professional services by the insured. Attach additional sheets as necessary. Photocopies of any pertinent documents which contain this information may be attached instead.

- | | | | |
|---|--------------------|----------------------------------|--|
| 25. Case Resulted in: (Check one)
<input type="checkbox"/> Settlement <input type="checkbox"/> Judgment <input type="checkbox"/> Arbitration Award | 26. Date Resolved: | 27. Total Amount of Award:
\$ | 28. Total Paid on Behalf of Physician:
\$ |
|---|--------------------|----------------------------------|--|

- | | | |
|--|------------------|--------------------|
| 29. Name and Location of Court/Arbitrator: | 30. Filing Date: | 31. Docket Number: |
|--|------------------|--------------------|

I certify under penalty of perjury under the laws of the State of California that to the best of my knowledge the information provided within this report and any attachments is true and correct.

Signature of Responsible Agent or Insurer

Name and Title (Printed or Typed) Date

11. (Continued):

Name:

License Number:

Address (if available):

24. (Continued):

Summary of facts:

*The following is the text of Business and Professions Code, Section 804.5:

The Medical Board of California may request a licensee, health care facility, self-insured governmental agency, or professional liability insurer that is required pursuant to Section 804 to comply with a request for medical records of a patient, or a copy of any depositions in a case that discusses the care, treatment or medical condition of a person, to permit representatives of the board to obtain copies of these records from the custodians of these records subject to reasonable costs to be paid by the Medical Board of California.